St Luke's PHYSICIAN GROUP

New Patient Registration Form

Pharmacy_____ **Phone #**_____
Pharmacy Address _____

New Patient Registration Form (PLEASE PRINT) TODAY'S DATE_____

How did you learn about our practice? Physician (PCP)_____
Relative__ Friend__ Website___ Phone book___ Newspaper__ Other __

Patient's Full Name _____ Age___

Home Address _____
City _____ **State** ___ **Zip** _____

Home Phone Number _____ Mobile Phone Number _____

Emergency Contact Person _____ Emergency Phone Number _____

Sex M___ F___ Relationship to Patient_____

Patient's Email Address _____

Patient's Date of Birth _____

Sex M__ F__ **Marital Status** (circle one) Single Married Widowed Divorced

Race (optional) Caucasian __ Hispanic __ African American __ Asian__ Other_____
Nationality American__ Puerto Rican__ Italian__ Indian__ Other_____

Patient's Employer _____ (if not employed is patient Retired? __ Student? __ Homemaker? __ Unemployed? __)

Patient Employer Address _____
City _____ State _____ Zip _____

Employer Phone Number _____ Extension ____

Responsible Party Information (Guarantor)
Who is Financially Responsible for the Account? The responsible party can never be a child.
Is the Responsible Party the same as the Patient information? Yes___ No__ (if no please fill in the information below)

Name _____

Address _____ **City** _____ **State** ___ **Zip** ____

Phone Number _____

Guarantor DOB _____

Email Address _____

If patient is a MINOR, fill in responsible parent or guardian:

Patient/Guardian Name _____

Patient/Guardian Address _____ City _____ State ____ Zip ____

Patient/Guardian Phone Number _____

Patient/Guardian Email Address _____

I acknowledge the above information is correct and I accept financial responsibility For any services offered for my dependant or myself.

Signature _____ **Date** _____

Primary Insurance Information
Name of Primary Insurance _____
Primary Insurance Address _____
City _____ **State** ____ **Zip** _____
Insurance Phone Number _____
Policy Number _____ Group # _____

Is the Patient the subscriber for the Primary Insurance? Yes ___ No ___
(If no, please complete this section.

Subscriber Relationship to Patient (circle one) SELF SPOUSE CHILD OTHER _____
Subscriber Name _____
Subscriber Address _____
Subscriber City _____ **State** _____ **Zip** _____
Subscriber Date of Birth _____ **Sex** M F
Subscriber Phone_____
Subscriber Employer _____
Subscriber Employer Address _____
City _____ State _____ Zip _____
Subscriber Employer Phone _____

Secondary Insurance Information (if applicable)
Name of Secondary Insurance _____
Secondary Insurance Address _____
City _____ **State** ____ **Zip** _____
Insurance Phone Number _____
Policy Number _____ Group # _____

Subscriber Relationship to Patient (circle one) SELF SPOUSE CHILD OTHER _____
Subscriber Name _____
Subscriber Address _____
Subscriber City _____ **State** _____ **Zip** _____
Subscriber Date of Birth _____ **Sex** M F
Subscriber Phone_____
Subscriber Employer _____
Subscriber Employer Address _____
City _____ State _____ Zip _____
Subscriber Employer Phone _____

Tertiary Insurance Information (if applicable)
Name of Tertiary Insurance _____
Tertiary Insurance Address _____
City _____ **State** ____ **Zip** _____
Insurance Phone Number _____
Policy Number _____ Group # _____

Subscriber Relationship to Patient (circle one) SELF SPOUSE CHILD OTHER _____
Subscriber Name _____
Subscriber Address _____
Subscriber City _____ **State** _____ **Zip** _____
Subscriber Date of Birth _____ **Sex** M F
Subscriber Phone_____
Subscriber Employer _____
Subscriber Employer Address _____
City _____ State _____ Zip _____
Subscriber Employer Phone _____